Case Management Agency Application

For the Behavioral Health Division Home and Community Based Waiver Programs

Please complete all pages and submit any required additional documentation

Note: ***This application DOES NOT guarantee certification. Applicants must meet all certification requirements***

In addition to this application, a Wyoming Medicaid Provider Enrollment Application and Agreement must be completed and submitted for the agency. The agency will need to obtain a National Provider Identifier (NPI#) in which all treating providers will be linked to. For more information regarding the NPI#, please contact the Behavioral Health Division (BHD) at 777-7115.

1. _____
Company and Practice Name (Doing Business As-DBA)

2. _____
Legally Authorized Representative

3. **Telephone:** Home: ( ) _____ Work: ( ) _____

Cell: ( ) _____ Email: _____

Fax: ( ) _____ Other: ( ) _____

4. **Address:** Mailing Address: _____

_____
City State Zip

Physical Address: _____
(If different from mailing)

_____
City State Zip

5. **Federal Employer Identification Number (FEIN):**_____. (All Agencies must have an FEIN in order to establish a group in which to link all treating providers for billing purposes)

6. Names of all owners/operators/managers for the agency. (List all names that an individual has used during their lifetime).

_____
First and Last Name

_____
First and Last Name

_____
First and Last Name

7. **For all owners/operators:**

   College Degree(s) or Credit Hours Completed and Name and Physical Address of University or College: ***Please send an official college transcript for all owners/operators directly to the BHD. Copies of a diploma are not accepted.***

Name of Individual	Degree Awarded / Credit Hours Completed	Name and Physical Address of University or College

You may attach a separate piece of paper if needed

8. List of all case managers employed by the agency:

First and Last Name of Employee	Other Names Used:

You may attach a separate piece of paper if needed

9. For all case managers:

   College Degree(s) or Credit Hours Completed and Name and Physical Address of University or College: ***Please send an official college transcript for all case managers directly to the BHD. Copies of a diploma are not accepted.***

Name of Individual	Degree Awarded / Credit Hours	Location Received

You may attach a separate piece of paper if needed

10. Have you, if a sole proprietor, or any of the owners/operators/employees ever been a certified provider for the Wyoming Home and Community Based Waiver Program and/or the Children's Mental Health Waiver?

    _____Yes _____ No **if "Yes," under what name and time period were you/they certified?**

    _____

    _____

    _____

    _____

11. Have you, if a sole proprietor or any of the owners/operators/employees ever been convicted of an offense in a court of law? (Other than minor traffic offenses)

    _____Yes _____No Name of Individual_____

    _____Yes _____No Name of Individual_____

    _____Yes _____No Name of Individual_____

    _____Yes _____No Name of Individual_____

    _____Yes _____No Name of Individual_____

    If "Yes," give dates, details and penalties for each occurrence on an attached sheet of paper. An Answer of "Yes" to this question does not constitute an automatic bar to certification.

12. Have you, if a sole proprietor, or any of the owners/operators/employees been substantiated for abuse or neglect by the Department of Family Services (DFS) or been convicted of a misdemeanor or felony affecting another person's health or safety in Wyoming or any other state?

    _____Yes _____No Name of Individual_____

    _____Yes _____No Name of Individual_____

    _____Yes _____No Name of Individual_____

    _____Yes _____No Name of Individual_____

    _____Yes _____No Name of Individual_____

13. Have you or any of the owners/operators/employees ever been sanctioned, debarred, suspended, excluded or convicted of a criminal offense related to Medicare/Medicaid or any other State or Federal program?

    _____Yes _____No Name of Individual_____

    _____Yes _____No Name of Individual_____

    _____Yes _____No Name of Individual_____

    _____Yes _____No Name of Individual_____

    _____Yes _____No Name of Individual_____

    By applying for this certification, Criminal Background (DCI/FBI) and/or DFS screenings will be conducted on you if a sole proprietor, and for any owners/operators/case managers of the agency. *(Previous background screenings may be used as long as the BHD Release of Information is submitted. Background screenings are good for a maximum of five years from the date of the screening.)*

Please select which waiver/s you are requesting certification in

_____**Acquired Brain Injury Waiver** _____**Child (DD) Waiver** _____**Children's Mental Health Waiver**

_____**Supports Waiver** _____ **Comprehensive Waiver**

Previous Work Experience for all owners/operators/case managers. Please list separately for each owner/operator/employed case manager

Name of Individual _____

Employer:_____Address:_____.

From: (Mo/Yr)_____To: (Mo/Yr)_____Hours per Week:_____.

Job Title: _____Supervisor_____.

Phone:_____Your duties or role in the agency_____.

_____.

****

Employer:_____Address:_____.

From: (Mo/Yr)_____To: (Mo/Yr)_____Hours per Week:_____.

Job Title: _____Supervisor_____.

Phone:_____Your duties or role in the agency_____.

_____.

_____.

****

Employer:_____Address:_____.

From: (Mo/Yr)_____To: (Mo/Yr)_____Hours per Week:_____.

Job Title: _____Supervisor_____.

Phone:_____Your duties or role in the agency_____.

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Employer:_____Address:_____.

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Job Title: _____Supervisor_____.

Phone:_____Your duties or role in the agency_____.

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Employer:_____Address:_____.

From: (Mo/Yr)_____To: (Mo/Yr)_____Hours per Week:_____.

Job Title: _____Supervisor_____.

Phone:_____Your duties or role in the agency_____.

_____.

_____.

****

Employer:_____Address:_____.

From: (Mo/Yr)_____To: (Mo/Yr)_____Hours per Week:_____.

Job Title: _____Supervisor_____.

Phone:_____Your duties or role in the agency_____.

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_____.

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Name of Individual _____

Employer:_____Address:_____.

From: (Mo/Yr)_____To: (Mo/Yr)_____Hours per Week:_____.

Job Title: _____Supervisor_____.

Phone:_____Your duties or role in the agency_____.

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_____.

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Phone:_____Your duties or role in the agency_____.

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Phone:_____Your duties or role in the agency_____.

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Employer:_____Address:_____.

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Phone:_____Your duties or role in the agency_____.

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From: (Mo/Yr)_____To: (Mo/Yr)_____Hours per Week:_____.

Job Title: _____Supervisor_____.

Phone:_____Your duties or role in the agency_____.

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****

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From: (Mo/Yr)_____To: (Mo/Yr)_____Hours per Week:_____.

Job Title: _____Supervisor_____.

Phone:_____Your duties or role in the agency_____.

_____.

_____.

****

Name of Individual _____

Employer:_____Address:_____.

From: (Mo/Yr)_____To: (Mo/Yr)_____Hours per Week:_____.

Job Title: _____Supervisor_____.

Phone:_____Your duties or role in the agency_____.

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****

Employer:_____Address:_____.

From: (Mo/Yr)_____To: (Mo/Yr)_____Hours per Week:_____.

Job Title: _____Supervisor_____.

Phone:_____Your duties or role in the agency_____.

_____.

_____.

****

Employer:_____Address:_____.

From: (Mo/Yr)_____To: (Mo/Yr)_____Hours per Week:_____.

Job Title: _____Supervisor_____.

Phone:_____Your duties or role in the agency_____.

_____.

_____.

CONFLICT OF INTEREST DISCLOSURE

You are required to disclose if you have a conflict of interest. In order to determine if a conflict of interest does exist, the BHD needs you to check one or more of the boxes listed below if you have some interest in and to that entity AND that **entity is receiving payments from any of the Medicaid Waivers**. For purposes of this paragraph an interest would include but is not limited to being an employee, independent contractor, officer, director/CEO, board member or having ownership of shares in a corporation, membership interest in a limited liability company, beneficiary interest in a statutory trust, ownership interest in a partnership or limited partnership or an interest of any kind or nature that could affect the operations of the entity such as voting shares/rights or managerial rights.

A conflict of interest may be determined by the BHD to exist if you check a box in which you may have some interest as set forth above in and to the entity **that receives payment from the Medicaid Waivers.**

Please review the following list of entities and check any box in which you may have some interest as identified above.

- □ Nonprofit corporation in W.S. 17-6-101 et seq.
- □ Profit corporation in W.S. 17-16-101 et seq.
- □ Partnerships in W.S. 17-13-101 et seq.
- □ Limited Partnerships in W.S. 17-14-101 et seq.
- □ Limited Liability Companies in W.S. 17-15-101
- □ Statutory Trust in W.S. 17-23-101
- □ Sole proprietor interest in any company/business/entity
- □ Interest of any nature in any other entity listed in Title 17

If any of the above boxes have been checked, on a separate piece of paper please give the full legal name of the entity, any name under which the entity may be doing business (include trade names registered with any state), physical address of the entity, mailing address of the entity, phone number and fax number if available and describe in detail your interest.

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INSURANCE: Home and Community-Based Services (HCBS) waiver providers are responsible for the services they provide, and should have or be part of a risk protection program that includes appropriate insurance. HCBS waiver providers are not employees of the State of Wyoming.

The agency certifies that all information contained on this application is true and complete. The agency understands that any misrepresentation or falsifications may result in removal from certification consideration or suspension of current certification. The agency gives the State of Wyoming and its authorized agents permission to verify any job-related information given with this application.

The agency is responsible for ensuring that all employees qualify to provide case management services. All owners/operators/employees must abide by current Medicaid Documentation Standards and must complete and sign a current Medicaid Enrollment Application and Agreement. Any failure on the part of the agency to ensure qualifications of case management could result in termination of the Medicaid Provider Agreement and a referral to Medicaid's Program Integrity for all services billed by a case manager that did not qualify to provide services.

_____ _____.

Signature of Legally Authorized Representative **Date**

In addition to this application, the applicant/agency shall submit information and/or documentation for all of the following:

Company Description, Organization and Management

- € Company information, including how business is being formed, names of founders/officers (if applicable) and their roles, business location, and any association within another entity including but not limited to being a subsidiary or a partner or business associate.
- € Future Plans. (What does the agency envision for future growth, What are the goals of the agency in the next five years, ten years, does the agency have a mission statement, how do the future plans align with the mission statement)
- € Describes details on the ownership of the company, management team and board of directors (if applicable).
- € How the agency is organized, i.e., who is doing what and for what purpose.
- € Special skills of owners/employees.
- € Who is responsible for oversight of documentation and billing, ensuring implementation of policies and procedures, and adherence to employment practices within the organization.
- € Names of every state where company was either incorporated or authorized to do business as an entity described in Title 17 of Wyoming Statutes or as a sole proprietor.
- € Copy of certificate of Good Standing from the Secretary of State's Office.

Description of Services offered

- € Specific benefits of services offered from the participant's viewpoint such as attendance to other meetings (ex., attending DVR, IEP, DFS, or community housing meetings, assistance with other community referrals).
- € Distinguishing characteristics including descriptions of how organization will assist participants with referrals to available community resources during times of crisis or as critical needs arise.
- € How agency's services will have the capability to meet participant's needs.
- € Research and Development-Descriptions of how agency will keep up with best practices, trends, training opportunities for employees, etc….

Appendix

- € Additional documents, i.e., special certifications, credentials, licenses, references.

Demonstration of full comprehension of current IRS payroll tax rules-(*The agency may seek assistance on current IRS requirements from a legal entity providing such service. Information is also available through the Wyoming Business Council).*

- € Has set up applicable records for IRS reporting, filing and auditing requirements.